FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044289

Facility Name: SOMERSET PLACE

Address: 5009 SHERIDAN ROAD (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-0700 **Fax #** (773) 561-9843

IDPA ID Number: 364269377001

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	450	Intermediate (ICF)	450	164,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	450	TOTALS	450	164,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	149,214	1,382		150,596	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	149,214	1,382		150,596	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.69%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	406,736	96,544	40,445	543,725		543,725	(4,451)	539,274			1
2	Food Purchase		459,600		459,600	(26,280)	433,320	(1,197)	432,123			2
3	Housekeeping	292,529	67,792	39,087	399,408		399,408	(34,404)	365,004			3
4	Laundry	24,261	35,925	27,182	87,368		87,368		87,368			4
5	Heat and Other Utilities			314,736	314,736		314,736	6,204	320,940			5
6	Maintenance	216,067		124,645	340,712		340,712	31,672	372,384			6
7	Other (specify):* Security			101,600	101,600		101,600	4,852	106,452			7
8	**TOTAL General Services**	939,593	659,861	647,695	2,247,149	(26,280)	2,220,869	2,676	2,223,545			8
	B. Health Care and Programs											
9	Medical Director			10,200	10,200		10,200		10,200			9
10	Nursing and Medical Records	2,404,390	56,262	7,030	2,467,682		2,467,682	64,753	2,532,435			10
10a	Therapy	18,392			18,392		18,392	13,984	32,376			10a
11	Activities	286,380	28,330	8,150	322,860		322,860	(2,423)	320,437			11
12	Social Services	582,248	11,410	3,589	597,247		597,247	3,705	600,952			12
13	Nurse Aide Training			1,476	1,476		1,476		1,476			13
14	Program Transportation			2,525	2,525		2,525		2,525			14
15	Other (specify):*							12,033	12,033			15
16	**TOTAL Health Care and Programs**	3,291,410	96,002	32,970	3,420,382		3,420,382	92,051	3,512,433			16
	C. General Administration											
17	Administrative	122,350		425,626	547,976		547,976	(226,565)	321,411			17
18	Directors Fees											18
19	Professional Services			693,567	693,567	(9,731)	683,836	(569,894)	113,942			19
20	Dues, Fees, Subscriptions & Promotions			87,819	87,819		87,819	(57,313)	30,506			20
21	Clerical & General Office Expenses	308,713	30,168	252,107	590,988		590,988	122,122	713,110			21
22	Employee Benefits & Payroll Taxes			833,972	833,972	26,280	860,252	(31,070)	829,182			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,294	4,294		4,294	3,277	7,571			24
25	Other Admin. Staff Transportation			13,541	13,541		13,541	(9,964)	3,577			25
26	Insurance-Prop.Liab.Malpractice			87,419	87,419		87,419	3,177	90,596			26
27	Other (specify):*							59,122	59,122			27
28	**TOTAL General Administration**	431,063	30,168	2,398,345	2,859,576	16,549	2,876,125	(707,107)	2,169,018			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,662,066	786,031	3,079,010	8,527,107	(9,731)	8,517,376	(612,380)	7,904,996			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SOMERSET PLACE #0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			57,774	57,774		57,774	555,780	613,554			30
31	Amortization of Pre-Op. & Org.			6,590	6,590		6,590		6,590			31
32	Interest							2,236,554	2,236,554			32
33	Real Estate Taxes			546,282	546,282	9,731	556,013	9,002	565,015			33
34	Rent-Facility & Grounds			2,744,175	2,744,175		2,744,175	(2,730,620)	13,555			34
35	Rent-Equipment & Vehicles			28,629	28,629		28,629	9,305	37,934			35
36	Other (specify):*							1,148,932	1,148,932			36
37	**TOTAL Ownership**			3,383,450	3,383,450	9,731	3,393,181	1,228,953	4,622,134			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			152	152		152		152			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,375	246,375		246,375		246,375			42
43	Other (specify):*			220,000	220,000		220,000	(220,000)				43
44	**TOTAL Special Cost Centers**			466,527	466,527		466,527	(220,000)	246,527			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,662,066	786,031	6,928,987	12,377,084		12,377,084	396,573	12,773,657			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(136,813)	30		9
10	Interest and Other Investment Income	(211,676)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(144,000)	21		24
25	Fund Raising, Advertising and Promotional	(12,417)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,235)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(545,912)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,059,175)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,455,748		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,455,748		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 396,573		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SOMERSET PLACE

ID# 0044289

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (4,213)	21	1
2	THEFT LOSS	(162)	21	2
3	RELATED PARTY - FORGIVENESS OF DEBT	(10,001)	21	3
4	RELATED PARTY - TRUST FEES	(200)	20	4
5	RELATED PARTY - LLC FEE	(225)	20	5
6	JURY DUTY	(34)	10	6
7	PRIOR YEAR LEGAL FEES	(653)	19	7
8	ERIC ROTHNER - MANAGEMENT FEE	(300,000)	17	8
9	NON-ALLOWABLE SALARY	(220,000)	43	9
10	CAPITALIZED REPAIRS & MAINTENANCE	(2,136)	6	10
11	ICLTC - COPE	(8,288)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			11,974	(16,425)								(4,451)	1
2	Food Purchase	(72)		(1,125)									(1,197)	2
3	Housekeeping			4,683	(39,087)								(34,404)	3
4	Laundry													4
5	Heat and Other Utilities			6,204									6,204	5
6	Maintenance	(2,136)		34,373	(565)								31,672	6
7	Other (specify):*			4,852									4,852	7
8	**TOTAL General Services**	(2,208)		60,961	(56,077)								2,676	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)		70,148			(5,361)						64,753	10
10a	Therapy			13,984									13,984	10a
11	Activities			5,415	(7,838)								(2,423)	11
12	Social Services			5,094	(1,389)								3,705	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			12,033									12,033	15
16	**TOTAL Health Care and Programs**	(34)		106,674	(9,228)		(5,361)						92,051	16
	C. General Administration													
17	Administrative	(300,000)		112,821	(113,425)	74,039							(226,565)	17
18	Directors Fees													18
19	Professional Services	(653)	10,285	16,537	(596,063)								(569,894)	19
20	Fees, Subscriptions & Promotions	(21,180)	425	4,505	(41,063)								(57,313)	20
21	Clerical & General Office Expenses	(166,611)	10,001	323,562	(44,830)								122,122	21
22	Employee Benefits & Payroll Taxes				(31,070)								(31,070)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,277									3,277	24
25	Other Admin. Staff Transportation			176	(10,140)								(9,964)	25
26	Insurance-Prop.Liab.Malpractice			3,177									3,177	26
27	Other (specify):*			49,047		10,075							59,122	27
28	**TOTAL General Administration**	(488,444)	20,711	513,102	(836,590)	84,114							(707,107)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(490,686)	20,711	680,737	(901,895)	84,114	(5,361)						(612,380)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOMERSET PLACE # 0044289 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(136,813)	668,301	24,292									555,780	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(211,676)	2,422,806	25,424									2,236,554	32
33	Real Estate Taxes			9,002									9,002	33
34	Rent-Facility & Grounds		(2,742,975)	12,355									(2,730,620)	34
35	Rent-Equipment & Vehicles			9,305									9,305	35
36	Other (specify):*		1,148,932										1,148,932	36
37	**TOTAL Ownership**	(348,489)	1,497,064	80,378									1,228,953	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(220,000)											(220,000)	43
44	**TOTAL Special Cost Centers**	(220,000)											(220,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,059,175)	1,517,775	761,115	(901,895)	84,114	(5,361)						396,573	45

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				SOMERSET REAL ESTATE, LLC		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 2,742,975	SOMERSET REAL ESTATE, LLC		$	$ (2,742,975)	1
2	V	21	FORGIVENESS OF DEBT		SOMERSET REAL ESTATE, LLC		10,001	10,001	2
3	V	32	INTEREST INCOME	28,568	SOMERSET REAL ESTATE, LLC			(28,568)	3
4	V	32	INTEREST EXPENSE		SOMERSET REAL ESTATE, LLC		2,451,374	2,451,374	4
5	V	36	INSURANCE EXPENSE		SOMERSET REAL ESTATE, LLC		227,568	227,568	5
6	V	19	ACCOUNTING FEES		SOMERSET REAL ESTATE, LLC		10,285	10,285	6
7	V	20	TRUST FEES		SOMERSET REAL ESTATE, LLC		200	200	7
8	V	36	AMORTIZATION		SOMERSET REAL ESTATE, LLC		921,364	921,364	8
9	V	30	DEPRECIATION		SOMERSET REAL ESTATE, LLC		668,301	668,301	9
10	V	20	LLC FEE		SOMERSET REAL ESTATE, LLC		225	225	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,771,543			$ 4,289,318	$ * 1,517,775	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 11,974	$ 11,974	15
16	V	2	FOOD				(1,125)	(1,125)	16
17	V	3	HOUSEKEEPING				4,683	4,683	17
18	V	5	UTILITIES				6,204	6,204	18
19	V	6	REPAIRS AND MAINT.				34,373	34,373	19
20	V	7	EMP. BEN. - GEN. SERV.				4,852	4,852	20
21	V	10	NURSING				70,148	70,148	21
22	V	10A	THERAPY				13,984	13,984	22
23	V	11	ACTIVITIES				5,415	5,415	23
24	V	12	SOCIAL SERVICES				5,094	5,094	24
25	V	15	EMP. BEN. - HEALTHCARE				12,033	12,033	25
26	V	17	ADMINISTRATIVE				112,821	112,821	26
27	V	19	PROFESSIONAL FEES				16,537	16,537	27
28	V	20	DUES, SUBSCRIPTIONS				4,505	4,505	28
29	V	21	CLERICAL AND GENERAL				323,562	323,562	29
30	V	24	SEMINARS				3,277	3,277	30
31	V	25	AUTO EXPENSE				176	176	31
32	V	26	INSURANCE				3,177	3,177	32
33	V	27	EMP. BEN. - GEN. ADMIN.				49,047	49,047	33
34	V	30	DEPRECIATION				24,292	24,292	34
35	V	32	INTEREST				25,424	25,424	35
36	V	33	REAL ESTATE TAXES				9,002	9,002	36
37	V	34	BUILDING RENT - UNRELATED				12,355	12,355	37
38	V	35	EQUIPMENT RENTAL				9,305	9,305	38
39	Total			$			$ 761,115	$ * 761,115	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 16,425	CARE CENTERS, INC.	100.00%	$	$ (16,425)	15
16	V	19	ACCOUNTING	15,000				(15,000)	16
17	V	19	ANCIL ADMIN FEE	54,000				(54,000)	17
18	V	19	BOOKEEPING	91,800				(91,800)	18
19	V	19	DATA PROCESSING	16,200				(16,200)	19
20	V	19	LEGAL	41,063				(41,063)	20
21	V	19	MANAGEMENT FEE	378,000				(378,000)	21
22	V	19	PROFESSIONAL FEES						22
23	V	20	ADVERTISING	41,063				(41,063)	23
24	V	25	REBILL BUS	10,140				(10,140)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	31,070				(31,070)	26
27	V	1	REBILL. PAYROLL DIETARY						27
28	V	3	REBILL. PAYROLL HSKPNG	39,087				(39,087)	28
29	V	6	REBILL. PAYROLL MAINT.	565				(565)	29
30	V	10	REBILL. PAYROLL NURSING						30
31	V	10A	REBILL. PAYROLL THPY CONS.						31
32	V	11	REBILL. PAYROLL ACTIVITIES	7,838				(7,838)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	1,389				(1,389)	33
34	V	17	REBILL. PAYROLL ADMIN.	113,425				(113,425)	34
35	V	21	REBILL. PAYROLL CLERICAL	44,830				(44,830)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 901,895			$	$ * (901,895)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$	$	15
16	V	15	EMP. BEN HEALTHCARE						16
17	V	17	ADMINISTRATIVE				74,039	74,039	17
18	V	27	EMP. BEN GEN. ADMIN.				10,075	10,075	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 84,114	$ * 84,114	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 44,156	$ 44,156	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	49,517				(49,517)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,517			$ 44,156	$ * (5,361)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 210,257	$ 210,257	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	210,257				(210,257)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 210,257			$ 210,257	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Relative	Administrative	0	see attached	4.95	9.90%	CCI salary	$ 4,394	17-07	1
2	Eric Rothner	Relative	Administrative	0	see attached	4.85	6.74%	Salary	80,000	17-01	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 84,394		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	150,596	$ 11,974	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		150,596	(1,125)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	150,596	4,683	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		150,596	6,204	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	150,596	34,373	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		150,596	4,852	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	150,596	70,148	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	150,596	13,984	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	150,596	5,415	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	150,596	5,094	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		150,596	12,033	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	150,596	112,821	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		150,596	16,537	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		150,596	4,505	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	150,596	323,562	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		150,596	3,277	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		150,596	176	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		150,596	3,177	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		150,596	49,047	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		150,596	24,292	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		150,596	25,424	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		150,596	9,002	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		150,596	12,355	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		150,596	9,305	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 761,115	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.
Street Address 150 FENCL LANE
City / State / Zip Code HILLSIDE, IL. 60162
Phone Number (708)449-9090
Fax Number (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		74,039	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			10,075	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 84,114	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 44,156	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 44,156	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 210,257	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 210,257	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Building Partnership	X		Mortgage	$149,915	1/28/99	$ 18,800,000	$ 28,605,081		prime+1	$ 2,451,374	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$149,915		$ 18,800,000	$ 28,605,081			$ 2,451,374	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(214,820)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (214,820)	14
15	TOTALS (line 9+line14)						$ 18,800,000	$ 28,605,081			$ 2,236,554	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income			Money Market			$	$			$ (211,676)	1
2	Interest Inc. - Bldg Co.			Repair Escrow							(5,626)	2
3	Interest Inc. - Bldg Co.			Replacement Reserve							(22,942)	3
4	Allocation from Care Centers, Inc										25,424	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (214,820)	21

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 601,326	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 568,811	2
3. Under or (over) accrual (line 2 minus line 1).		$ (32,515)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 587,799	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 9,731	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 565,015	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	572,691	10
1999	568,847	11
2000	559,809	12

2001 accrual = 559,809 (2000 RE Tax) x 1.05

Allocation from Care Centers, Inc. $9002

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOMERSET PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-304-081, 03-0120-567	Home Office Allocation	$ 66,986.83	$ 6,626.45
2.	14-08-408-003-000	Long Term Care Property	$ 552,862.49	$ 552,862.49
3.	14-08-408-031-000	Long Term Care Property	$ 6,946.58	$ 6,946.58
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 626,795.90	$ 566,435.52

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 184,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 9

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 6,590
2. Number of Years Over Which it is Being Amortized: 1
3. Current Period Amortization: 6,590
4. Dates Incurred: _____

Nature of Costs: Financing Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 1,100,000	1
2	Allocation from Care Centers, Inc.			6,331	2
3	TOTALS			$ 1,106,331	3

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1999	$ 9,900,000	$ 253,846	35	$ 282,857	$ 29,011	$ 825,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		742,067	19,135		34,781	15,646	95,846	68
69	Financial Statement Depreciation			18,075			(18,075)		69
70	TOTAL (lines 4 thru 69)		$ 10,642,067	$ 291,056		$ 317,638	$ 26,582	$ 920,846	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,642,067	$ 291,056		$ 317,638	$ 26,582	$ 920,846	1
2	BLDG RENOVATION	1999	7,400			370	370	1,079	2
3	HEATER RENOVATION	1999	520			26	26	76	3
4	PIPING RENOVATION	1999	3,829			191	191	542	4
5	PLUMBING RENOVATION	1999	638			32	32	91	5
6	DOOR	1999	750			38	38	104	6
7	ELEVATOR RENOVATION	1999	597			30	30	83	7
8	PLUMBING RENOVATION	1999	1,296			65	65	179	8
9	PLUMBING RENOVATION	1999	1,980			99	99	264	9
10	ELECTRIC RENOVATION	1999	959			48	48	128	10
11	ELECTRIC RENOVATION	1999	225			11	11	29	11
12	BOILER RENOVATION	1999	643			32	32	85	12
13	BOILER RENOVATION	1999	2,075			104	104	277	13
14	BOILER RENOVATION	1999	869			43	43	115	14
15	A/C RENOVATION	1999	1,950			98	98	253	15
16	ELECTRIC RENOVATION	1999	964			48	48	120	16
17	A/C RENOVATION	1999	2,478			124	124	310	17
18	WATER HEATER	1999	5,870			294	294	711	18
19	WATER HEATER	1999	933			47	47	114	19
20	LOCKS	1999	744			37	37	83	20
21	HOT WATER PUMP	1999	933			47	47	114	21
22	A/C IMPROVEMENT	1999	996			50	50	117	22
23	BOILER	1999	839			42	42	95	23
24	LOOSE SILL REMOVAL	2000	74,460			3,723	3,723	7,446	24
25	SINKS	2000	3,398			170	170	326	25
26	EXIT CONTROL LOCK	2000	1,647			82	82	157	26
27	GENERATOR	2000	1,414			71	71	136	27
28	PHONE SYSTEM INSTALL	2000	26,841			1,342	1,342	2,572	28
29	HOT WATER HEATER REP	2000	9,500			475	475	871	29
30	PAINT	2000	1,939			97	97	178	30
31	BLINDS	2000	6,223			311	311	570	31
32	CARPET INSTALLATION	2000	750			38	38	67	32
33	GAS PUMP REPAIR	2000	1,235			62	62	109	33
34	TOTAL (lines 1 thru 33)		$ 10,806,962	$ 291,056		$ 325,885	$ 34,829	$ 938,247	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,806,962	$ 291,056		$ 325,885	$ 34,829	$ 938,247	1
2	ELECTRIC WIRING	2000	1,143			57	57	100	2
3	PAINT	2000	3,809			190	190	317	3
4	WINDOW TREATMENTS	2000	6,562			328	328	547	4
5	TILES	2000	2,377			119	119	198	5
6	RENOVATION OF 117 BA	2000	22,815			1,141	1,141	1,902	6
7	ROOF LEAK REPAIR	2000	1,247			62	62	103	7
8	NEW BOILER	2000	784			39	39	65	8
9	PLUMBING WORK	2000	5,550			278	278	463	9
10	EXHAUST SYSTEM REPAI	2000	66,798			3,340	3,340	5,567	10
11	BOILER REPAIR	2000	601			30	30	50	11
12	NEW CARPETING	2000	3,400			170	170	283	12
13	PAINT	2000	559			28	28	44	13
14	PAINT	2000	217			11	11	17	14
15	PAINT	2000	564			28	28	44	15
16	FACADE PROJECT	2000	9,451			473	473	749	16
17	12 KNOB SETS	2000	919			46	46	73	17
18	SNEEZE GUARD	2000	7,631			382	382	605	18
19	FIRE ALARM SYSTEM RE	2000	1,100			55	55	87	19
20	EXHAUST MOTOR REPAIR	2000	3,730			187	187	296	20
21	PLUMBING REPAIR	2000	9,974			499	499	790	21
22	DRYWALL	2000	502			25	25	40	22
23	LANDSCAPING	2000	46,025			2,301	2,301	3,643	23
24	AWNING FRAMES & FIXT	2000	10,000			500	500	792	24
25	TILES INSTALLATION	2000	10,558			528	528	836	25
26	NEW CARPETING	2000	10,000			500	500	792	26
27	SEWER REPAIR	2000	653			33	33	52	27
28	LIGHT FIXTURES	2000	1,642			82	82	130	28
29	REPLACE THERMOSTAT	2000	1,719			86	86	136	29
30	PAINT	2000	1,873			94	94	141	30
31	AVIARY	2000	7,966			398	398	597	31
32	NEW BOILER DRAIN	2000	598			30	30	45	32
33	LIGHT FIXTURES,LAMPS	2000	76,263			3,813	3,813	5,720	33
34	TOTAL (lines 1 thru 33)		$ 11,123,992	$ 291,056		$ 341,738	$ 50,682	$ 963,471	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,123,992	$ 291,056		$ 341,738	$ 50,682	$ 963,471	1
2	DRYWALL	2000	717			36	36	54	2
3	ELECTRICAL SUPPLIES	2000	622			31	31	47	3
4	LIFE SAFETY CODE REV	2000	1,239			62	62	93	4
5	FIRE DOORS	2000	1,864			93	93	140	5
6	NEW FRAME	2000	3,500			175	175	263	6
7	PAINTING OFF ALL RES	2000	13,000			650	650	975	7
8	ELEVATOR REPAR $2610	2000	1,305			65	65	92	8
9	PAINT	2000	677			34	34	48	9
10	PAINT	2000	683			34	34	48	10
11	NURSE CALL STATION	2000	807			40	40	57	11
12	TILES	2000	598			30	30	43	12
13	AC REPAIR	2000	652			33	33	47	13
14	AC REPAIR	2000	1,729			86	86	122	14
15	ELECTRIC WIRING	2000	1,500			75	75	106	15
16	HOPKINS ELEVATOR	2000	1,301			65	65	87	16
17	HI-GRADE	2000	519			26	26	35	17
18	SEWER REPAIR	2000	760			38	38	51	18
19	DRYWALL	2000	1,483			74	74	99	19
20	ELECTRICAL WIRING	2000	900			45	45	60	20
21	FIRE ALARM PANEL REP	2000	595			30	30	40	21
22	FIRE ALARM PANEL REP	2000	505			25	25	33	22
23	STOVE REPAIR	2000	2,899			145	145	181	23
24	PAINTING	2000	19,800			990	990	1,238	24
25	BOILER REPAIR	2000	1,250			63	63	74	25
26	LIGHT FIXTURES,LAMPS	2000	41,012			2,051	2,051	2,393	26
27	UPGRADE FROM LIGHTIN	2000	2,375			119	119	139	27
28	REPLACE PUMP IN HOT	2000	2,117			106	106	124	28
29	GLASS BLOCKS	2000	500			25	25	27	29
30	BOILER TREATMENT	2000	997			50	50	54	30
31	LOCKER ROOM AIR HAND	2000	606			30	30	33	31
32	WATER PUMP	2000	539			27	27	29	32
33	SEWER LINES CLEANING	2000	1,861			93	93	101	33
34	TOTAL (lines 1 thru 33)		$ 11,232,904	$ 291,056		$ 347,184	$ 56,128	$ 970,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,232,904	$ 291,056		$ 347,184	$ 56,128	$ 970,404	1
2	REPLACING DRAINS I	2000	475			24	24	26	2
3	GAS PIPING INSTALLAT	2000	2,655			133	133	144	3
4	TILING	2000	10,029			501	501	543	4
5	SHELVES	2001	990			50	50	50	5
6	BATHROOM RENOVATION	2001	819			41	41	41	6
7	ELECTRICAL REPAIRS	2001	5,401			270	270	270	7
8	BLINDS	2001	1,550			78	78	78	8
9	ALCO SALES & SERVICE	2001	741			34	34	34	9
10	PAINT	2001	1,113			51	51	51	10
11	AC REPAIR	2001	1,357			62	62	62	11
12	BATHROOMS RENOVATION	2001	1,067			49	49	49	12
13	TILING	2001	783			36	36	36	13
14	TILING	2001	559			26	26	26	14
15	NURSE CALL STATION	2001	700			32	32	32	15
16	KING OF TILE, INC.	2001	942			39	39	39	16
17	DURALINE OVERHEAD	2001	3,028			126	126	126	17
18	TILES	2001	3,838			160	160	160	18
19	TILES	2001	500			21	21	21	19
20	TRANSFORMER FOR HEAT	2001	445			18	18	18	20
21	WINDOW INSTALLATION	2001	15,000			563	563	563	21
22	COOLER REPAIR	2001	751			29	29	29	22
23	OUTSIDE LIGHTING	2001	6,003			225	225	225	23
24	LANDSCAPING	2001	590			23	23	23	24
25	CLEAN UP SEWER LINES	2001	2,539			85	85	85	25
26	DOORS	2001	2,610			87	87	87	26
27	FAN REPAIR	2001	561			16	16	16	27
28	BOILER REPAIR	2001	3,247			95	95	95	28
29	LANDSCAPING	2001	1,153			34	34	34	29
30	INSTALL EMERGENCY	2001	1,113			33	33	33	30
31	SEWER PUMP	2001	879			26	26	26	31
32	REPAIR GROUND PUMP	2001	2,963			74	74	74	32
33	INSTALL EMERGENCY LI	2001	4,295			108	108	108	33
34	TOTAL (lines 1 thru 33)		$ 11,311,600	$ 291,056		$ 350,333	$ 59,277	$ 973,608	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,311,600	$ 291,056		$ 350,333	$ 59,277	$ 973,608	1
2	SHOWERS RENOVATION	2001	758			19	19	19	2
3	PAINT	2001	792			17	17	17	3
4	PAINT	2001	1,749			36	36	36	4
5	COOLER REPAIR	2001	1,221			25	25	25	5
6	HEATING AND AC	2001	54,659			1,139	1,139	1,139	6
7	SELF-CLOSING DOOR	2001	4,900			102	102	102	7
8	DOORS	2001	800			13	13	13	8
9	HAND RAILS	2001	2,500			42	42	42	9
10	ROOF REPAIR	2001	2,150			36	36	36	10
11	BOILER TREATMENT	2001	997			13	13	13	11
12	REPAIR MOTOR PUMP	2001	2,819			35	35	35	12
13	EXHAUST FAN	2001	1,446			18	18	18	13
14	PIPE SYSTEM UPGRADE	2001	7,289			91	91	91	14
15	SEWER LINE REPAIR	2001	2,563			32	32	32	15
16	SEWER LINE REPAIR	2001	3,200			40	40	40	16
17	WINDOW SHADES	2001	1,072			9	9	9	17
18	LANDSCAPING	2001	53,671			447	447	447	18
19	HVAC REPLACEMENT	2001	3,116			39	39	39	19
20	PAINT	2001	890			45	45	45	20
21	PAINT	2001	1,246			62	62	62	21
22	GLASS FOR METAL FRAM	2001	1,785			149	149	149	22
23	GLASS FOR WINDOWS	2001	935			47	47	47	23
24	REPLACE MOTOR UPGRAD	2001	970			24	24	24	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,463,128	$ 291,056		$ 352,813	$ 61,757	$ 976,088	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI alloc		1996	1996	$ 112,042	$ 2,873	35	$ 3,201	$ 328	$ 16,273	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Care Centers, Inc.			2001	319	42	20	8	(34)	8	9
10	Allocation from Care Centers, Inc.			2000	135	3	20	7	4	12	10
11	Allocation from Care Centers, Inc.			1999	2,006	51	20	100	49	290	11
12	Allocation from Care Centers, Inc.			1998	828	21	20	41	(20)	152	12
13	Allocation from Care Centers, Inc.			1997	11,752	208	20	648	440	3,789	13
14	Allocation from Care Centers, Inc.			1996	12,917	170	20	681	511	2,676	14
15	Allocation from Care Centers, Inc.			1997	1,363	316	20	59	(257)	192	15
16	Allocation from Care Centers, Inc.			1994		38	20		(38)		16
17	Allocation from Care Centers, Inc.			1993		11	20		(11)		17
18											18
19	Somerset Real Estate, LLC			1999	165,717	4,249	20	8,286	4,037	24,168	19
20	Somerset Real Estate, LLC			1999	100,018	2,565	20	5,001	2,436	12,503	20
21	Somerset Real Estate, LLC			1999	70,455	1,807	20	3,523	1,716	8,514	21
22	Somerset Real Estate, LLC			1999	76,104	1,951	20	3,805	1,854	8,878	22
23	Somerset Real Estate, LLC			1999	65,049	1,668	20	3,252	1,584	7,317	23
24	Somerset Real Estate, LLC			1999	109,573	2,809	20	5,479	2,670	9,982	24
25	Somerset Real Estate, LLC			2000	6,139	157	20	307	150	486	25
26	Somerset Real Estate, LLC			2000	7,650	196	20	383	187	606	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 742,067	$ 19,135		$ 34,781	$ 15,606	$ 95,846	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,473,372	$ 436,015	$ 247,818	$ (188,197)		$ 738,349	71
72	Current Year Purchases	45,672	13,774	3,537	(10,237)		3,537	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,519,044	$ 449,789	$ 251,355	$ (198,434)		$ 741,886	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers allocation		$ 54,179	$ 8,290	$ 8,306	$ 16	10	$ 26,730	76
77	Facility	VAN	1999	5,000	980	1,000	20		2,417	77
78	Facility	INSTALL SEATBELTS	2000	780	250	78	(172)		124	78
79										79
80	TOTALS			$ 59,959	$ 9,520	$ 9,384	$ (136)		$ 29,271	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	15,148,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	750,365	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	613,552	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(136,813)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,747,245	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers, Inc.				12,355			5
6	Parking Lot Rental				1,200			6
7	TOTAL				$ 13,555 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 37,934 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,429	$	$ 1,429
2	Books and Supplies		47		47
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,476	$	$ 1,476
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,476			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	25

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,997	$ 13,383	1
2	Cash-Patient Deposits	79,032	79,032	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,118,524	5,118,524	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,162	188,272	6
7	Other Prepaid Expenses	21,897	21,897	7
8	Accounts Receivable (owners or related parties)	17,870	678,467	8
9	Other(specify): See supplemental schedule	365,426	1,288,327	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,651,908	$ 7,387,902	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,100,000	13
14	Buildings, at Historical Cost		9,900,000	14
15	Leasehold Improvements, at Historical Cost	812,247	1,412,952	15
16	Equipment, at Historical Cost	174,109	2,424,109	16
17	Accumulated Depreciation (book methods)	(114,548)	(2,134,832)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		279,777	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,879)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	243,797	11,151,565	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,115,605	$ 24,110,692	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,767,513	$ 31,498,594	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 674,631	$ 674,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,967	67,967	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	391,430	391,430	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,786	20,786	31
32	Accrued Real Estate Taxes(Sch.IX-B)	587,799	587,799	32
33	Accrued Interest Payable		203,811	33
34	Deferred Compensation	4,212	4,212	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	(143,753)	(143,753)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,603,072	$ 1,806,884	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		28,605,081	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 28,605,081	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,603,072	$ 30,411,965	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,164,441	$ 1,086,629	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,767,513	$ 31,498,594	48

*(See instructions.)

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,780,771	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,780,771	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,523,670	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,140,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,383,670	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,164,441	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,689,014	1
2	Discounts and Allowances for all Levels	(938)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,688,076	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	30	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	938	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 968	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	211,676	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 211,676	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	34	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,900,754	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,247,149	31
32	Health Care	3,420,382	32
33	General Administration	2,859,576	33
	B. Capital Expense		
34	Ownership	3,383,450	34
	C. Ancillary Expense		
35	Special Cost Centers	220,152	35
36	Provider Participation Fee	246,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,377,084	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,523,670	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,523,670	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,216	2,435	$ 74,984	$ 30.79	1
2	Assistant Director of Nursing	5,186	5,699	129,362	22.70	2
3	Registered Nurses	4,438	4,877	114,900	23.56	3
4	Licensed Practical Nurses	48,488	53,283	869,047	16.31	4
5	Nurse Aides & Orderlies	139,549	153,351	1,182,337	7.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,170	2,385	18,392	7.71	8
9	Activity Director	9,408	10,338	126,436	12.23	9
10	Activity Assistants	16,465	18,093	159,944	8.84	10
11	Social Service Workers	43,007	47,260	582,248	12.32	11
12	Dietician					12
13	Food Service Supervisor	6,260	6,879	106,894	15.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,323	42,113	299,842	7.12	15
16	Dishwashers					16
17	Maintenance Workers	12,775	14,039	216,067	15.39	17
18	Housekeepers	39,910	43,857	292,529	6.67	18
19	Laundry	3,661	4,023	24,261	6.03	19
20	Administrator					20
21	Assistant Administrator	1,535	1,687	42,350	25.10	21
22	Other Administrative	260	260	80,000	307.69	22
23	Office Manager					23
24	Clerical	38,066	41,831	308,713	7.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,625	2,885	33,760	11.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	414,342	455,295	$ 4,662,066 *	$ 10.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	816	$ 24,020	01-03	35
36	Medical Director	monthly	10,200	09-03	36
37	Medical Records Consultant	quarterly	1,440	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,650	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	312	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psycho-Social	per consult	2,200	12-3	47
48	Care Centers (see attached)		25,652	various	48
49	TOTAL (lines 35 - 48)	823	$ 65,474		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	137	3,940	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	137	$ 3,940		53

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Blake Willey	Asst. Admin.	0	$ 42,350
Eric Rothner	Administrative	0	80,000
Administrator salary paid thru Care Centers (see page 6B)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,350

B. Administrative - Other

Description	Amount
Chris Wayer - Management Fee	$ 200
Eric Rothner - Management Fee (adjusted on page 5)	300,000
Nachum Langner - Management Fee	12,000
Administrative payroll (see page 6B)	113,425
TOTAL (agree to Schedule V, line 17, col. 3)	$ 425,625
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	$ 30,837
Personnel Planners	Unemployment Tax Cons.	2,440
Schwartz & Freeman	Legal	50
Michael Best	Legal	1,815
Buyer & Rubin	RE Tax Appeal	9,731
Legatarchitects	Architects	713
Chicago Voluteer	Court Filing Fee	180
Winston & Strawn	Legal	603
various - see attached	Computer Services	47,104
various - see attached	various - see attached	2,475
Daiwa	Audit Fees	1,559
Care Centers, Inc.	various - see attached	596,063
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 693,570

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,822
Unemployment Compensation Insurance	78,388
FICA Taxes	356,648
Employee Health Insurance	242,184
Employee Meals	26,280
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Employee Tax	7,319
Pension Expense	54,206
Employee Physicals	4,617
Misc. Employee Welfare	2,325
Holiday Party	3,393
TOTAL (agree to Schedule V, line 22, col.8)	$ 829,182

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,608
Health Care Worker Background Check	2,136
(Indicate # of checks performed 181)	
Advertising & Promotion	12,417
Dues & Subscriptions	11,006
Licenses & Fees	4,251
Allocation from Care Centers, Inc	4,505
Less: Public Relations Expense	
Non-allowable advertising	(12,417)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,506

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,294
Allocation from Care Centers, Inc.	3,277
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,571

**See instructions.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Il Council Long Term Care $18216**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,954** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **246,375**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,280** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **30**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees